Solano County Health & Social Services

Solano County
Mental Health Managed Care
Provider Manual

August 2011

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Table of Contents

Table of Contents

I. Phone and Address Directory

Claims Submission 707-784-8013
Mail to:
Solano County Mental Health Plan
Managed Care Claims Division
275 Beck Avenue **MS 5-235**
Fairfield, CA 94533

Credentialing Updates 707-784-8014
Mail to:
Solano County Mental Health Plan
Managed Care Credentialing
275 Beck Avenue **MS 5-235**
Fairfield, CA 94533

Screening, Referral and Customer Services Line 800-547-0495
Solano County Health & Social Services Information and Referral Call Center 211

Solano County Mental Health Services

Managed Care Fax Number 707-425-4320
Mental Health Plan 800-547-0495
Psychiatric Emergency Team 707-428-1131

Partnership HealthPlan of California

Information Line 707-863-4100
Automated Eligibility Verification.....707-863-4140
Or 800-557-5471
Member Services (Medi-Cal & Health Kids) 707-863-4120
Or 800-863-4155
Member Services (Partnership*Advantage*) 866-264-3626
Care Coordination.....707-863-4276
Or 800-809-1350
Fax Numbers
Main 707-863-4117
Member Services 707-863-4415

II. Managed Care in Solano County

Medi-Cal is California's version of the Federal Medicaid program. It provides for the health care of low-income individuals and families. Most people are enrolled with Medi-Cal automatically because they are receiving either AFDC or SSI. Others apply for it directly because they are low income and have a continuing or disabling medical condition. The rules and regulations that govern this program are very complex and confusing, yet it is a valuable form of health insurance for people who would otherwise have none.

Partnership HealthPlan of California (PHC) was formed and became operational in May of 1994. It is the Partnership's responsibility to maintain a system of doctors, hospitals and other health care service providers (pharmacy, laboratory, specialists, etc.) to meet the health care needs of the Solano citizens receiving Medi-Cal.

The Partnership HealthPlan of California is like an HMO (Health Maintenance Organization). The State and Federal governments have calculated what the Medi-Cal costs would be in Solano County under fee-for-service and pay those funds directly to the PHC on a capitated basis. The HealthPlan, in turn, contracts with the necessary health care providers. The two essential elements of this system are: (1) that each Medi-Cal recipient will select one of the contracting doctors or medical groups to be their primary care physician, and (2) that the primary care physician will be paid on a capitated basis rather than a fee-for-service method. What this means is that providers are paid a set amount (the capitation) each month for each person who has selected them as their primary care physician. Based on their contracts with PHC, the physicians are expected to provide a range of specific services to each individual as needed. Should the individual need other health care services or require a specialist, the primary care physician will make a referral to a contracted specialist. It has been demonstrated that this method of contracting, capitated payments and established referral networks encourages and expands preventive and primary care services and reduces emergency and hospital-based care. This of course is to the benefit of the individual receiving care as well as helping to control the overall cost of health care.

The Partnership HealthPlan of California has recruited a significant number of individual physicians, clinics and medical groups to serve Medi-Cal recipients under this new system.
<u>What does this mean for Mental Health Services?</u>

Historically, there have been two separate Medi-Cal funded mental health systems. One is the Short-Doyle Medi-Cal system that is the County operated mental health program (known as Coordinated Services). The other has been the fee-for-service system which is composed of the private hospitals, psychiatrists and psychologists who have billed the State for services they provide. These two systems have had separate providers, separate billing mechanisms, separate rules for reimbursable services and different rates of fees for reimbursement, yet the same beneficiary could receive services from each system. As an example, a Medi-Cal beneficiary may have an emotional crisis and receive services from the Psychiatric Emergency Team (Short-Doyle), then be hospitalized at East Bay Hospital (fee-for-service), and upon discharge be scheduled to see private psychiatrist (fee-for-service) in Vacaville for follow-up but be assigned a County case manager (Short-Doyle) to assist with maintaining their independent living status. These are different providers, different services, different reimbursements yet the same beneficiary.

The State Department of Mental Health and the State Department of Health Care Services have been working to develop a plan to bring the Short-Doyle and fee-for-service Medi-Cal mental health programs together into a single system. This is known as "consolidation." As a long-range plan, Solano County is a field test county in the consolidation of these systems.

With the start-up of the Medi-Cal Managed Care System (Partnership HealthPlan of California) in May 1994, planning for mental health services took a slightly different path. As described previously, all the former fee-for-service Medi-Cal funds (including mental health expenditures) are paid to the PHC. It should be noted that this is only those funds that have been part of the fee-for-service system and does not affect the funding or rules for the Short-Doyle system. In light of the long range plans for the consolidation of mental health systems, the Partnership HealthPlan of California agreed to identify the amount of money spent on fee-for-service mental health services and pass it through to the County ("carve out") to provide for and manage that mental health system. The County now contracts with private providers in order to continue these services. Initially the contract with the PHC to "carve out" the mental health funds to the County required that we contract only with providers who were currently authorized to be Medi-Cal providers under the fee-for-service system (psychiatrists and psychologists). Waivers to this requirement were pursued with the State Department of Health Services, and the County is now able to contract with Licensed Clinical Social Workers and Licensed Marriage, Family and Child Therapists as well.

Even though the contract with the PHC brings together the Mental Health Short-Doyle and managed care systems under a single management, the funds cannot be consolidated and must be accounted for separately. Additionally, the types of services to be purchased with the managed care funds will be limited to acute inpatient services and outpatient services with specified providers. Expenditures will be closely monitored as the level of funding is limited (capitated), and the County will be responsible (at risk) for any cost overruns.

Under the former fee-for-service system, an individual on Medi-Cal seeking mental health services would have to call around to various providers until they found someone willing to see them. Under the new managed care system, that same individual calls 1-800-547-0495, briefly discusses their needs and is referred to a contracted provider in their area offering services that match their needs. This is called pre-authorization. The provider is then given an authorization to provide a limited number of sessions or visits with that beneficiary. The provider is to submit a brief evaluation and treatment plan in order to be authorized additional visits or sessions with that beneficiary. They will be paid only for services that have been pre-authorized.

The County initially contracted with a firm, United Behavioral Health, to staff the 800 number (access line), provide service authorization (utilization review), and pay the provider's claims. Effective December 1995, Solano County staff assumed all these functions. This is only for those services previously provided within the fee-for-service system and is known as the Mental Health Managed Care system. The Short-Doyle system continues to operate under its Coordinated Services Plan and serve beneficiaries who meet target population definitions. Beneficiaries are able to receive Short-Doyle services and Mental Health Managed Care services as appropriate to their need.

What role does Kaiser Foundation Health Plan play in providing Mental Health Services?

Kaiser Foundation Health Plan will provide covered Mental Health Services, including assessment, screening, crisis services, outpatient treatment, and medication support for PHC Medi-Cal members assigned to Kaiser Foundation Health Plan.

Solano Mental Health Plan is responsible for provision of long-term care services; e.g., case management, residential treatment, crisis intervention and Institution for Mental Disease (IMD)/State Hospital care; for PHC Medi-Cal members assigned to Kaiser Foundation Health Plan who meet medical necessity criteria for coordinated services, including:

- Seriously emotionally disturbed children or adolescents;
- Adults and older adults who have a serious and/or persistent mental disability which interferes substantially with primary activities of daily living and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support and rehabilitation for a long or indefinite period of time;
- Adults or older adults who require, or are at risk of requiring, acute psychiatric treatment because of a mental disorder with symptoms of psychosis, suicidality, or danger to self or others.

III. Definitions and Acronyms

The following is a list of terms and their abbreviations as commonly used in this manual

Access Line/Unit: Access to the system of care is through a centralized 1-800 number for all Medi-Cal beneficiaries seeking mental health treatment. In addition, by calling this number, providers and beneficiaries are able to ask questions from the clinical staff about authorization for mental health services, referrals, or express a concern or complaint. A provider may also call this number to obtain information on claims, and/or contract provider relations and member services.

Beneficiary: Medi-Cal eligible individual (Solano County resident status) requesting mental health treatment. Parents or a legal guardian may also call to request services on behalf of the beneficiary.

Care Manger: A mental health clinician or nurse who links beneficiaries to mental health services. Other functions include screening/assessment, authorization, coordination, referral, providing information and education, reviewing ongoing care and making a decision about medical necessity. Primarily talks to providers, hospital staff, and beneficiaries regarding mental health services.

County Medical Services Program (CMSP): This is a County funded program to provide health care services for adult between 21 and 64 years of age. This is a separate program from Partnership HealthPlan of California's Managed Care Program. Psychological services are not funded under this program. A CMSP beneficiary may receive psychiatric services from a psychiatrist who is a State approved Medi-Cal provider.

Medical Necessity: The justification for mental health specialty services. Medical necessity for access to the mental health system is provisionally determined by an initial phone screening by a Care Manager. Medical necessity for ongoing care is based upon the results of an evaluation by an approved provider and the agreement of the Care Manager.

Medi-Cal: California's version of the Federal Medicaid program. This is a State and Federal funded health insurance for low-income individuals and families.

Mental Health Plan (MHP): An entity that enters into a contract with the California Department of Mental Health to provide directly or arrange and pay for specialty mental health services to beneficiaries in a county. A MHP may be a county, counties acting jointly or another governmental or non-governmental entity.

Pre-Authorization: Providers must call a Care Manager to obtain authorization for mental health services prior to those services beginning. Outpatient pre-authorization is obtained by calling 800-547-0495. In those situations involving hospitalization, the Solano County Psychiatric Emergency Team designated staff will screen for admission and authorize if appropriate. The Psychiatric Emergency Team must be called directly for inpatient admission requests. *Emergency services do not require pre-authorization.*

Partnership HealthPlan of California (PHC): A Medi-Cal countywide system, under contract to the State, designed to provide a more economical organization of health care resources on a case management basis and to improve continuity of care.

Providers: Licensed mental health professionals and hospitals that have contracted with Solano County Mental Health Managed Care to provide evaluation and treatment to Medi-Cal beneficiaries.

Provider Relations Coordinator: Managed Care staff member tasked to oversee provider recruitment, retention and contractual activities and assisting with processing of complaints, concerns and grievances.

Screening: The process of triaging callers, checking eligibility, gathering demographic data, determining problem, assessing for emergency, and providing appropriate referral on intervention.

Share of Cost (SOC): The amount determined by Medi-Cal an individual or family can afford to pay towards medical expenses before Medi-Cal will pay for medical expenses. The individual must meet (pay) the share of cost amount to become Medi-Cal eligible. A person with an unmet SOC is not Medi-Cal eligible.

IV. Access Protocols: Outpatient Services

Screening and Referral (Access) Line

Assistance is available 24-hours a day, seven days a week by calling 1-800-547-0495.

Callers using a rotary phone should remain on the line for the next available operator or leave a message.

Note: All Routine Services Must Be Pre-Authorized

Assessment Procedures

Pre-authorization *is not required for emergency services*. Most consumers will go to their local emergency room to be evaluated by the Solano County Psychiatric Emergency Team for urgent care; however, if any eligible Medi-Cal beneficiary/consumer contacts a provider for emergency services, pre-authorization for treatment is not required. The Provider must contact Solano MHP as soon as possible afterwards to receive retro-authorization for treatment provided.

Care Manager will verify eligibility

Calls regarding non-Medi-Cal eligible individuals will be assessed and triaged to an appropriate resource.

Kaiser eligibles will be referred to closest Kaiser Behavioral Health Department

Care Manager will obtain information necessary to establish need for assessment and appropriate referral:

- Determine eligibility
- Presenting problem
- Brief recent treatment history
- Current risk factors
- Geographic location
- Appropriate clinician and specialty areas
- Other clinician characteristics requested or deemed appropriate by the Care Manager i.e. gender, ethnicity, language, other cultural preferences, etc.

Emergency procedures will be utilized as needed, including telephone safety checks, emergency response services triage, child and elder abuse reporting, Tarasoff Warning, etc. Referral to the Solano County Psychiatric Emergency Team may also be facilitated for immediate risk assessment.

A referral will be made based upon level of care required to either an internal provider or external provider, or possibly to a community resource. When a referral is made to an external provider, the caller will be provided with the clinician's name, address, phone number, an authorization number and be instructed to call the clinician for an appointment.

Interpreter services

- The county will arrange interpreter services for providers who need to utilize this service. Providers are encouraged to utilize professional interpreters rather than family members.

Access Standards and Monitoring

Access standards as defined below will be monitored for:

- **Urgent assessments:** the provider will schedule appointments within 48 hours.
- Routine (non-urgent) outpatient evaluations: the provider will respond to call from beneficiary within five business days and;
- The provider will schedule an appointment within 10 business days of the beneficiary's call.

Outpatient Authorization

There are two types of authorizations that a Provider receives from a Care Manager:

- Authorization for outpatient visits and;
- Authorization for medication monitoring**.**

Beneficiaries must call the Provider within 30 days from the Authorization Start Date. The Provider has a total of 45 days from the Authorization Start Date in which to see the Beneficiary or the initial authorization will be invalid. **In addition**, all other authorizations that have not been used within 12-months from approval date will be invalid.

This policy does not apply to **medication management.** Authorizations for **medication management** may be used over a period of 24-months from initial approval date. However, the initial authorization must be used within 45 days from the authorization start date to remain valid.

Authorization Letters

A letter will automatically be sent to the beneficiary, unless beneficiary requests letter not be sent, which will confirm that an authorization has been made. (See attachment A for sample)

An authorization letter will also be sent to the provider confirming the authorization. (See attachment B for sample)

V. Charting Requirements

Progress Note Requirements

Progress notes are required for each contact with a client. Progress notes must be distinct, non-repetitive, and individualized to each session. Solano MHP has a standard *Progress Note* (attachment C) available or providers may use their own form. Each note must be legible and include:

- Beneficiary name and date of birth
- Date, duration, and location of service
- Type of service provided
- Intervention(s) used for the service
- Beneficiary's response to the intervention described
- Beneficiary progress toward achieving their identified goal(s) and plans for future treatment

- Referrals to community resources, when appropriate
- Provider's printed or stamped name, signature and license type
- An account of the Beneficiary's culture and language in understanding the Beneficiary's problems
- Documentation that justifies the time billed

Authorization Guidelines – all ages

- Emergency or urgent assessments require immediate phone report by clinician (1-2 sessions). Complete Biopsychosocial Assessment and Outpatient Treatment Progress Report forms (attachments D and E).
- Beneficiaries referred for medication must be authorized.
- A Medication evaluation (one session) plus up to nine ongoing medication-monitoring sessions may be authorized. Complete Psychiatric Medication Evaluation/Progress Report form (attachment F).
- **Sessions may be authorized for a frequency of once per week or other frequency as appropriate and medically necessary.** If frequency of more than once per week is required, provider must obtain authorization. The request may be done in writing or by calling 1-800-547-0495 for verbal authorization.

Children and Adolescent Beneficiaries – 17 years old and younger

- Four initial sessions will be authorized based on the beneficiary's provisional diagnosis.
- Up to ten additional sessions may be authorized upon submission of the *Biopsychosocial Assessment* (attachment D) provided sufficient medical necessity criteria is documented.
- Another ten additional session may be authorized upon submission of a current *Outpatient Treatment Progress Report* (attachment E) provided sufficient medical necessity criteria is documented.
- Authorizations are valid up to twelve months from the date of initial authorization.
- Authorization is limited to a maximum of twenty-four sessions per year.

Adult Beneficiaries – 18 years old and older

- Four initial sessions will be authorized based on the beneficiary's provisional diagnosis.
- Up to seven additional sessions may be authorized upon submission of the *Biopsychosocial Assessment* (attachment D) provided sufficient medical necessity criteria is documented.
- Another seven additional session may be authorized upon submission of a current *Outpatient Treatment Progress Report* (attachment E) provided sufficient medical necessity criteria is documented.
- Authorizations are valid up to twelve months from the date of initial authorization.
- Authorization is limited to a maximum of eighteen sessions per year.

Requests for Continued Authorization

- The provider is responsible for requesting continued care, if recommended, by sending in *Outpatient Treatment Progress Report*, or by calling (800) 547-0495 to report the results of urgent assessments.

Note: The standard time for processing an *Outpatient Treatment Progress Report* is fourteen calendar days after receipt.

Providers are encouraged to send clinical information or call prior to the end of the currently authorized group of sessions to avoid the risk of non-authorization and non-payment of services.

Closing Summary

Providers must send a *Closing Summary Report* (see attachment G) to the care managers when treatment is completed, or if member drops out of treatment.

Note: The standard time for submitting a *Closing Summary Report* is fourteen calendar days after last session.

VI. After Hours Message

As a provider in Solano MHP Network, you must ensure you have an after-hour message when you are unavailable. All providers are required to add the following language to their normal telephone message/recording:

"If you are a Solano Medi-Cal beneficiary and need immediate assistance, call the Solano County Access Unit at 1-800-547-0495. If you are experiencing a life threatening emergency, please call 9-1-1."

If you speak more than one language in your practice, you must duplicate the message in all of those languages.

VII. Medi-Cal Medical Necessity Criteria: Outpatient

Consumers must meet the following criteria for medical necessity and be Medi-Cal eligible in order for services to be reimbursable**. All three criteria – 1, 2, and 3 – must be met.**

1) **Diagnosis:**

Included Diagnosis:

- Pervasive Developmental Disorders, Excluding Autistic Disorder
- Attention Deficit and Disruptive Behavior Disorders
- Feeding and Eating Disorders of Infancy or Early Childhood
- Elimination Disorders
- Other Disorders of Infancy, Childhood, or Adolescence
- Schizophrenia and Other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Paraphilia
- Gender Identity Disorders
- Eating Disorders
- Impulse-Control Disorders Not Elsewhere Classified

- Adjustment Disorders
- Personality Disorders, Excluding Antisocial Personality Disorder
- Medication-Induced Movement Disorder
- An Included Diagnosis when an Excluded Diagnosis is also Present

Excluded Diagnosis:

- Autistic Disorder
- Learning Disorders
- Motor Skills Disorder
- Community Disorders
- Autistic Disorder – Other Pervasive Developmental Disorders are Included
- Tic Disorders
- Delirium, Dementia, Amnesic, and Other Cognitive Disorders
- Mental Disorders Due to a General Medical Condition
- Substance-Related Disorder
- Sexual Dysfunction
- Sleep Disorders
- Antisocial Personality Disorder
- Other Conditions That May be a Focus of Clinical Attention, Except
- Medication Induced Movement Disorders Which are Included
- Mental Retardation

2) Impairment Criteria:

A beneficiary may receive services for an included diagnosis when an excluded diagnosis is also present.

Must have one of the following as a result of the mental disorder(s) identified in the diagnostic criteria.

- A significant impairment in an important area of life functioning.
- A probability of significant deterioration in an important area of life functioning.
- Children also qualify if there is a probability the child will not progress developmentally as individually appropriate.

3) Intervention-Related Criteria:

Must have all of the following:

- The focus of proposed intervention is to address the condition identified in impairment criteria
- It is expected the beneficiary will benefit from the proposed intervention by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning, and/or for children it is probable the child will progress developmentally as individually appropriate.
- The condition would not be responsive to physical healthcare-based treatment

VIII. Access Protocols: Inpatient Care

Initial Inpatient Authorization

Emergency Inpatient admissions do not require pre-authorization, however the hospital must contact the Psychiatric Emergency Team as soon as practical to obtain authorization for continuing stays**.** Call the Solano County Psychiatric Emergency Team (707) 428-1131 (24 Hrs. a day)

Acute hospital admissions from Institutes for Mental Disease (IMD) will be **coordinated** with the County's IMD Case Manager or the Solano County Psychiatric Emergency Team in the Case Manager's absence.

Note: The Psychiatric Emergency Team will serve as the central communication point for children and adolescents referred for hospitalization. They will be referred to the Psychiatric Emergency Team whenever possible.

Inpatient Care: if Call is Received by Care Management Team

Care Management Team receives call from Medi-Cal beneficiary or Provider via (800) 547-0495.

Care Manager verifies eligibility of beneficiary.

If beneficiary needs emergency care, Care Manager will transfer call to Solano County Psychiatric Emergency Team, alerting them of beneficiary's status. The Care Manager releases call to Psychiatric Emergency Team (who does assessment for level of care).

If inpatient care is needed, Solano County Psychiatric Emergency Team will locate and secure a bed in an approved Medi-Cal contracted facility.

If inpatient care is not needed, Solano County Psychiatric Emergency Team will triage to community services and/or refer to Mental Health Managed Care for outpatient services.

Psychiatric Emergency Team will fax a form notifying of hospital admission to Care Manager.

If beneficiary is located **"out of county"** and is a Solano Partnership HealthPlan member, and it's determined by a Care Manager that admission is necessary into a non-contracted hospital, Solano MHP will initiate a Single Case Agreement with the hospital.

Beneficiary Calls or Walks into Psychiatric Emergency Team (PET)

If inpatient care is needed, Solano County Psychiatric Emergency Team will:

- Locate and secure a bed in an approved Medi-Cal contracted facility and facilitate beneficiary's transfer.
- Fax form to Managed Care authorizing hospital admission.
- If inpatient care is not needed, Solano County Psychiatric Emergency Team will triage to community services and/or refer to Mental Health Plan Access line for outpatient services.

Ongoing Inpatient Authorization

Care Manager will:

- Conduct utilization review of admission and continuing stay days.
- As part of utilization review, apply medical necessity criteria for authorization of reimbursement of continued stay.
- If medical necessity is not met, adverse decisions will be reviewed with appropriate medical staff.
- Solano MHP Hospital Liaison Unit or other designated staff will coordinate discharge planning and continuity of care.

IX. Eligibility Verification

Automated Eligibility System is available 24 hours a day - 7 days a week

Verifying Member Eligibility

Membership Eligibility: Provider is responsible to verify eligibility of beneficiary for the month of service. Verification is necessary every month for each recipient to assure accurate payments to providers of mental health care services. **This must be accomplished before services are provided.**

Partnership HealthPlan of California (PHC) website at http://www.partnershiphp.org/

The automated Eligibility System can be accessed by calling **(707) 863-4140 or (800) 557-5471.**

If Provider is unable to verify eligibility using the PHC website or Automated Eligibility Verification System, they may call the PHC Members Services Department (707) 863-4120 or (800) 863-4155.

Authorizations for services that cover more than one calendar month do not establish nor guarantee beneficiary's Medi-Cal eligibility; it is the Provider's responsibility to assure that services are provided to eligible Beneficiaries.

Individual Medi-Cal eligibility is established monthly by the Department of Social Services. Individual members who are eligible are classified into different "Aid Codes" which represent different Medi-Cal eligibility programs. All Medi-Cal recipients with identification number beginning with **County Code "48"** (Solano County) who are eligible to receive medical benefits under Medi-Cal or as Medicare/Medi-Cal crossovers are served through the Partnership HealthPlan of California.

When a beneficiary has Medicare and/or other insurance, the other insurance or Medicare must be pre-authorized and billed first. Medi-Cal will only reimburse what the beneficiary's other insurance does not cover, up to the allowed Medi-Cal reimbursement amount for the service rendered.

Share of Cost (SOC)

Depending upon a person's monthly income, Medi-Cal may determine that they must meet a SOC before Medi-Cal will pay for medical expenses. Therefore, the person may not be eligible for Medi-Cal benefits until their Share of Cost is met.

The SOC is met when the person has paid the provider, or has promised to pay the Provider.

X. Claims & Billing Instructions & Approved Service Codes

Billing Procedures

Please use the following procedures when billing Solano County Mental Health Plan (MHP) for pre-authorized services:

HCFA CMS-1500 (Outpatient) Form:

- The Provider must complete items 1 through 13 on the claim form and sign and date the sections 12 and 13 on the form. "Signature on file" is acceptable. Please use HCFA CMS-1500 form (attachment H).
- In item 11C, indicate “Solano County Medi-Cal.”
- The Provider must complete items 14 through 33.
- Enter appropriate diagnosis code(s) in box 21.
- Enter appropriate service code in box 24D - Use only approved service codes listed in this manual by Provider discipline.
- In box 23, enter authorization number from authorization letter.
- Box 31, signature of provider must be original (no copies, stamps or “signature on file”).

Solano Mental Health Plan Claim Form:

- You may use the Solano MHP Claim Form (attachment I) in lieu of the CMS-1500 form (attachment H).
- The Beneficiary must complete items 1 through 7g. on the form and sign and date the sections on the form entitled "Medical Authorization" and "Payment Authorization." "Signature on file" is acceptable.
- The Provider must complete items 8 through 24.
- Enter appropriate service code in item 16 – use only approved service codes listed in this manual by Provider discipline.
- In box 8, enter appropriate diagnosis code(s).
- In box 9, enter authorization number from authorization letter.
- Box 31, signature of provider must be original (no copies, stamps or “signature on file”).

UB04 (Inpatient/Outpatient Services) Form:

- The Provider must complete items 1 through 85 of the UB-04 (attachment J).

  Billing Tip: Information most likely to be left off of claim includes: Member’s social security number, diagnosis codes, authorization number and appropriate CPT code. One piece of missing/incorrect information can result in claim being rejected.

25-1 Long-Term Care Form (Used by Long-Term Care Facilities):

- The Provider must complete all items except 120-126 (complete items 3-116 as needed).
- Use one form per beneficiary.

Where to Mail Claims

For Outpatient, Acute Inpatient, IMD Professional Visit Claims:

Solano Mental Health Plan
Medi-Cal Claims Department
275 Beck Avenue MS 5-235
Fairfield, CA 94533-0677

For Long-Term Care Facilities and TARS:

Solano Mental Health Plan
Provider Relations
275 Beck Avenue MS 5-235
Fairfield, CA 94533-0677

Claims *must* be received in our Claim's Office within 60 days following the month in which services were rendered. This requirement is referred to as the 60-day billing limit. Claims received after 60 days may be denied.

Claims for family therapy must be billed under the name of the primary beneficiary.

Payment Policies

You have agreed to the Solano County Mental Health Managed Care Medi-Cal fee schedule. Reimbursement levels are determined by the practitioner's licensure (not degree) and the type of service (assessment or therapy) provided.

Medi-Cal guidelines do not allow payment of sessions for which a Beneficiary fails to show.

Medicare/Medi-Cal "Crossover" claims. Services for Solano County Medi-Cal Recipients with Medicare as the primary insurer do need pre-authorization from Solano MHP. Provider must bill Medicare prior to billing Medi-Cal. Ensure a copy of Medicare EOB is attached to claim. Claims must be received within 60 days of EOB date at Solano MHP.

Billing Tip: Attach a dated copy of Medicare/HMO EOB for the date of service, to the claim. Payment cannot be made without proof of payment/denial from HMO**.**

Professional visits to geriatric beneficiaries or beneficiaries under 21 confined in Long-Term Care Facilities. **Professional services for Beneficiaries require pre-authorization**. Please note the following Medi-Cal schedule:

- One initial evaluative interview and
- One or two additional sessions within the first month
- One session every two weeks thereafter
- Psychiatrist must contact Care Manager for additional authorization if they determine additional or other services are needed
- Please contact a Care Manager at (800)547-0495 for pre-authorization

Note: The Solano County Health & Social Services contract stipulates that all services must be pre-authorized in order to receive reimbursement.

Exceptions:
Psychologist and Masters Level Therapist case conference: (service code 99366) A case conference may be claimed once per calendar month per patient, without pre-authorization.

Long-Term Care Facility Claims: Solano County Medi-Cal beneficiaries are placed in Long Term Care Facilities and case managed by Solano County Mental Health staff.

Explanation of Benefit (EOB) Claims Voucher Mailed to Providers Details:

- Providers name & address
- Members' name
- Authorization numbers
- Date of service
- Amount you billed (your standard rate)
- Amount allowed (Medi-Cal Reimbursement Rate)
- Other insurance payment
- Co-payment
- Amount paid
- Explanation of Benefit (EOB) code which explains the action taken on the claim or reasons for denial of submitted charges.

Coordination of Benefits
Many Beneficiaries are covered under more than one insurance plan. When this is the case, the **"other insurance"** is considered to be the Primary Insurer. In order to control health care costs and to prevent overpayment of plan benefits, Solano MHP Medi-Cal Mental Health Managed Care Program applies standard coordination of benefit rules where applicable**.**

When Medi-Cal is the secondary insurer, Solano MHP will only reimburse, as the secondary payer, the difference between the Medi-Cal rates for the services billed, minus the payment amount by the primary insurer. The total reimbursement will not exceed Solano MHP Managed Care Medi-Cal rates.

Note: (M.D., Ph.D. and LCSW) - If you are not currently a Medicare Provider, you can download a provider application at the Centers for Medicare and Medicaid Services website at www.cms.gov or call 1-800-Medicare (1-800-633-4277) for assistance. If you are treating Medicare/Medi-Cal beneficiaries, it will be necessary for you to be Medicare authorized so that you will be able to bill Medicare.

Medicare Part A & B
Medi-Cal will reimburse **Medicare Part A (institutional services)** deductibles or coinsurance for aid codes specified in the State Medi-Cal Manual.

Medicare Part B (non-institutional)
Medical services for Medicare/Medi-Cal recipients will be reimbursed as explained above, with pre-authorization.

Claims missing the Medicare EOB will be denied.

Billing Inquiries
Billing inquiries may be made by calling **(800) 547-0495**.

An inquiry is used to reconcile claims that have over or underpayments or to request a tracer or status on a claim line that has not appeared on an EOB.

Inquiry time lines: Providers have six (6) months to inquire about a claim from the original date of the denial on the Solano MHP EOB. Inquiries made after six months are subject to denial.

If the issue is not resolved, the provider may submit an appeal within 90 days inquiry. See **Section XII** for problem resolution and appeals process.

Important Points Regarding Claims
Treatment of any Medi-Cal Beneficiary must be performed by the practitioner to whom the referral was made. *You may not bill in your name for treatment provided by another practitioner or an assistant.*

The provider must complete a new claim form if services extend 90 days beyond the last claim form signed by the beneficiary.

You may not in any case bill the beneficiary for amounts above the Medi-Cal rate.

Solano MHP will not reimburse for covered services that were improperly submitted to other insurance carriers.

Claims Processing Overview
All incoming paper claims and other documents are date stamped.

All claims are subject to a comprehensive series of edits and audits by Claim Representative.

Claims missing pertinent information e.g., beneficiary name, procedure codes, diagnosis codes, or billing amount will be returned to provider with a cover letter identifying missing information or other problems.

Claims that are denied are included on the Explanation of Benefits, (EOB) along with the reason why the claim was denied.

Billing Tip: Ensure each claim submitted is fully completed

Service Codes and Reimbursement Rates

Payable Psychiatrist Services

Effective January 1, 2003

New Code	Previous Code	Current Rate	Service Description
90801	90801	$ 135.00	Initial evaluative interview
90804	90804	$ 50.00	Individual medical psychotherapy, 20-30 minutes
90862	90862	$ 50.00	Pharmacologic management
90899	90899	Manually priced	Psychiatric service/therapy not listed under another code
99366	NA	$ 30.00	Case conference, ½ hour or more, face-to-face*
99367	9544	$ 30.00	Case conference, ½ hour or more, without face-to-face*

Note: Claims for services rendered prior to January 1, 2003 will be paid at the previous Medi-Cal reimbursement rates.

*Only one case conference per month per beneficiary is allowed.

Service Codes and Reimbursement Rates

Payable Psychologist Services

Effective January 1, 2003

New Code	Previous Code	Current Rate	Service Description
90801	90801	$ 78.00	Initial evaluative interview
90804	9500	$ 33.00	Individual psychotherapy, ½ hour
90806	9502	$ 67.00	Individual psychotherapy, 1 hour
90847	9510	$ 80.00	Family therapy, 1 ½ hours, maximum
90853	9506	$ 30.00	Group therapy, 1 hour, per session, per person (maximum 8 persons)
96101	9514	$ 45.00	Test administration, includes pre-interview, 1 hour
96101	9530	$ 45.00	Test scoring, 1 hour
99366	9546	$ 56.00	Case conference, 1 hour, face-to-face*
99367	NA	$ 56.00	Case conference, 1 hour, without face-to-face*
99499	9548	$ 15.00	Out of office call, payable only for visits to the first beneficiary at any given location on the same day

Note: Claims for services rendered prior to January 1, 2003 will be paid at previous Medi-Cal reimbursement rates.

* Only one case conference per month per beneficiary is allowed.

Psychological services in IMD's are not a covered Medi-Cal benefit. It is expected that the rate paid to the IMD by Solano County Mental Health Services be all-inclusive with the exception of psychiatry.

Service Codes and Reimbursement Rates

Payable Licensed Clinical Social Worker
And
Marriage, Family, Therapist Services

Effective January 1, 2003

New Code	Previous Code	Current Rate	Service Description
90801	90801	$ 74.00	Initial evaluative interview
90804	9500	$ 30.00	Individual psychotherapy, ½ hour
90806	9502	$ 60.00	Individual psychotherapy, 1 hour
90847	9510	$ 72.00	Family therapy, 1 ½ hours, maximum
90853	9506	$ 27.00	Group therapy, 1 hour, per session, per person (maximum 8 persons)
99366	9546	$ 50.00	Case conference, ½ hour or more, face-to-face*
99367	NA	$ 50.00	Case conference, ½ hour or more, without face-to-face*
99499	9548	$ 13.50	Out of office call, payable only for visits to the first beneficiary at any given location on the same day

Note: Claims for services rendered prior to January 1, 2003 will be paid at previous Medi-Cal reimbursement rates.

* Only one case conference per month per beneficiary is allowed.

XI. Provider Responsibilities

Medi-Cal beneficiaries receiving or seeking mental health services shall be informed of how to access the Problem Resolution process. They shall be provided or have easy access to brochures for Beneficiary Rights, Appeal Form, Grievance Form, and Request to Change Provider Form. These forms are mailed to the beneficiary upon first request for service. Beneficiaries shall be informed of their right to access advocate assistance if they wish to submit a grievance, appeal or expedited appeal at any time during the problem resolution process. Beneficiaries must also be informed of their option to request a State Fair Hearing.

At the request of the provider, Solano MHP will assist in the education and/or training of providers and their staff in Medi-Cal billing procedures.

Treatment shall be provided in a **culturally competent** manner by providing services in a language appropriate and culturally sensitive manner, in a setting accessible to diverse communities. Contact Solano MHP if you desire a copy of the Solano County Mental Health Services Cultural Competence Plan.

Notify beneficiaries they are entitled to the following rights:

- Respectful treatment by all mental health staff
- Service provided in a safe environment
- Informed consent to treatment and informed consent to prescribed medications and options available
- Protection of personal health information
- Participate in treatment planning
- Request a change in the level of care, change of therapist, and a second opinion
- Consideration of a problem or concern about services by the staff person or agency providing care
- File a Grievance regarding services
- File for a State Fair Hearing following an Action
- File an Appeal regarding an Action
- Delegate a person to act on their behalf during the Grievance, Appeal or State Fair Hearing process
- Culturally sensitive services
- Use of an interpreter at no cost
- Request and receive a copy of his/her medical records, and request they be amended or corrected
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- The right to an Advanced Health Directive

XII. Problem Resolution and Appeals Process

These procedures are a means to identify and resolve concerns and problems quickly and easily for both hospital and non-hospital provider's. The Access Unit line at (800) 547-0495 serves as the Customer Service Line providers can call to register a complaint or discuss informal problem resolution. Complaints or concerns may also be submitted in writing using the Complaint/Appeal Form (attachment K).

Send all correspondence to:

Solano County Mental Health Plan
Attn: QI Provider Appeals Coordinator
275 Beck Avenue, MS 5-235
Fairfield, CA 94533-0677

The Managed Care Program Manager has primary responsibility for the maintenance and review of the problem resolution and appeals process. The Program Manager is assisted by the Provider Appeals Coordinator and Provider Relations Coordinator.

Solano MHP will make every effort to provide informal problem resolution whenever possible. However, you have the right to access the appeals process at any time before, during, or after the process has begun when the complaint concerns a denied or modified request for Solano MHP payment authorization or the processing or payment of a providers claim to Solano MHP.

If a complaint cannot be resolved to the provider's satisfaction by informal means described in Billing Inquiries in **Section X**, the provider may file an appeal.

Grievances

Grievances are complaints for which a provider requests, in writing, a formal grievance committee hearing.

Providers may register a formal grievance if the complaint is not resolved to the provider's satisfaction. Formal grievances will be personally filed in writing at the Solano MHP Managed Care Office or by mail. There shall be a 25 working day resolution period during which time Solano MHP staff shall prepare a resolution to the provider in writing. If the proposed resolution is not satisfactory, the provider may request a meeting of the Grievance Review Committee.

The Grievance Committee is composed of the Managed Care Program Manager or designee, Medical Director or medical staff designee and two Mental Health Providers Members (licensure based on circumstance of complaint and/or licensure level of grievant). The committee will meet monthly based on need. A hearing will be scheduled to review the grievance complaint at the earliest possible date. Decisions of the Grievance Review Committee are binding unless reversed by a vote of the County upon the appeal.

Appeals for Non-Hospital Specialty Mental Health Services (Outpatient)

A Provider may file an appeal concerning the processing or payment of a claim, or a denied request for reimbursement of mental health services to Solano MHP. The appeal must include all supporting documentation regarding the provider's claim. **The written appeal must reach Solano MHP within 90 calendar days of the date of receipt of the non-approval of payment.**

Solano MHP will have 60 calendar days from receipt of the appeal to inform the provider in writing of the decision. This will include a statement of the reasons for the decision that addresses each issue raised by the provider and any action required by the provider to implement the decision. Solano MHP will also provide the name of a person who may be contacted regarding the status of the complaint

and/or appeal.

If the appeal concerns the denial or modification of a Solano MHP payment authorization request, Solano MHP will utilize personnel not involved in the initial denial or modification decision to determine the appeal decision.

If the appeal is upheld, the Provider Appeals Coordinator will notify the provider of the decision. The provider shall submit a revised request for payment authorization/claim to the Managed Care Unit within 30 calendar days from receipt of the Provider Appeals Coordinator's decision to approve the payment authorization request/claim.

If the appeal is denied or not granted in full, the provider will be notified of his/her further right (second level appeal) for review by the Provider Appeals Coordinator.

- If a second level appeal is requested, provider must submit request within 30 days of receipt of the appeal denial to the Solano County Mental Health Director.
- The provider will be notified in writing within 60 days of the provider's appeal to the Mental Health Director of his/her decision. The decision of the Mental Health Director shall be final.

If the Mental Health Director upholds the provider's appeal, the MHP will have 14 calendar days to approve the payment authorization or take any other corrective action described within the decision. The provider may be requested to submit a revised payment request under the circumstances of specific decisions by the MHP Mental Health Director.

Appeals for Acute Psychiatric (Hospital) Services

A hospital may file an appeal concerning the processing or payment of a claim, or concerning a denied request for reimbursement of psychiatric services to Solano MHP. The appeal should include all supporting documentation regarding the provider's claim. **The written appeal must reach the Solano County Mental Health Provider Appeals Coordinator within 90 calendar days of the date of receipt of the non-approval of payment.**

The MHP will have 60 calendar days from its receipt of the complaint and/or appeal to inform the hospital in writing of the decision, including a statement of the reasons for the decision that addresses each issue raised by the provider, and any action required by the hospital to implement the decision.

The Provider Appeals Coordinator shall not have been involved in the initial denial or modification decision.

If the appeal is upheld, the Provider Appeals Coordinator will notify the provider of the decision. The provider shall submit a revised request for payment authorization/claim to the Managed Care Unit within 30 calendar days from receipt of the Provider Appeals Coordinator's decision to approve the payment authorization request/claim.

If the appeal is denied or not granted in full, the hospital will be notified of the right to submit a second-level appeal to the Mental Health Director.

- If applicable, the hospital must submit a revised request for payment within 30 days from receipt

of the Provider Appeals Coordinator's decision to approve the payment authorization request/claim.

- If the Provider Appeals Coordinator does not respond within 60 calendar days to the appeal, the appeal shall be considered denied in full by Solano County Mental Health Managed Care.